The Joint Commission 2017 Medical Staff Standards Update

Session Code: TU07

Date: Tuesday, October 24

Time: 11:30 a.m. - 1:00 p.m.

Total CE Credits: 1.5

Presenter(s): Louis Goolsby, MD
OBJECTIVES

- Identify new standards and changes to the survey process
- Indicate common standards that could impact the Medical Staff
- Consider examples of compliance for common findings on survey
CHANGES IN THE SURVEY PROCESS

- The SAFER Matrix
- Antimicrobial Stewardship
- Ligature Risks for Behavioral Health Care Units
- Culture of Safety

SAFER MATRIX

- Survey Analysis for Evaluating Risk
- Effective January 1, 2017 for the Hospital Accreditation Program
- Standards no longer defined as Direct or Indirect and A or C
- Standards reported as frequency and likelihood of harm
Operational Definitions for SCOPE

- **Limited, An Outlier**
  - Unique occurrence that is not representative of routine/regular practice
- **Pattern, Process Variation**
  - Multiple occurrences or the potential to impact more than a limited number
- **Widespread, Process Failure**
  - Pervasive and systemic failure

Operational Definitions for LIKELIHOOD TO HARM

- **Low** — Rare for actual harm to occur as a result of the deficiency
- **Moderate** — Harm could happen, more likely as a contributing factor in certain situations
- **High** — Harm could happen at any time without any other circumstances or failures

Additional Changes with the SAFER Matrix

- All observations are Requirements for Improvement
- All RFIs addressed in a 60 day Evidence of Standards Compliance Report
- High risk RFIs require additional detail and will be highlighted for subsequent surveys
Antimicrobial Stewardship Program

- Medication Management Chapter
  - MM.09.01.01
  - 8 Elements of Performance
  - Effective January 1, 2017

Centers for Disease Control and Prevention

- 20% to 50% of antibiotics prescribed unnecessarily or inappropriately
- Antibiotic resistance related to
  - Two million illnesses each year
  - 23,000 deaths each year
ASP: Leadership (EP 1)
- Leaders establish antimicrobial stewardship as an organizational priority
- Medical Staff Leadership involved in performance improvement activities and infection control activities

ASP: Education (EP 2)
- The hospital educates LIPs involved in antimicrobial ordering, dispensing, administration and monitoring about antimicrobial resistance and ASP practices
- Education occurs on granting of initial privileges and periodically based on need

ASP Multidisciplinary Team (EP 4)
- Does not require a new committee
- Medical staff practitioners are required and infectious disease practitioners if available to the hospital
ASP Core Elements (EP 5)

- Tracking
  - Monitoring the ASP which may include antimicrobial prescribing and resistance patterns
- Reporting
  - Regularly reporting information to medical staff members on the ASP which may include antibiotic use and resistance
- Education
  - Regular education on the ASP which may include information on resistance and optimal prescribing

ASP Organization Approved Multidisciplinary Protocols (EP 6)

- Development of protocols require involvement of medical staff members
- Optimal antibiotic use for CAP, UTI, Skin and Soft Tissue, and Prophylaxis
- Guidance for Adult and Pediatric Antimicrobial Treatment
- Formulary restrictions or preapproval guidelines
- Guidance for intravenous to oral conversion

ASP Improvements

- EP 7: The hospital collects, analyzes and reports data on its ASP
- EP 8: The hospital takes action on improvement opportunities identified in its ASP
ASP: FPPE and OPPE

- What ASP data collection could be useful indicators of practitioner performance?
- Would data collected from ASP data on practitioner utilization of antimicrobials lead to a for-cause FPPE?

Ligature Risks for Behavioral Health

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units)

Environment of Care

- EC.02.06.01, Element of Performance 1
- require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states “Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided”. Therefore, ligature and self-harm risks must be identified and eliminated
Focus on Reducing Inpatient Suicides

- 1200 to 1500 inpatient suicides each year in the United States
- 70% to 75% by hanging
- Ligature risks are no longer acceptable in areas specified for the treatment of behavioral health care patients with suicide risk

The Approach to Ligature Risks

- Identify and remove all ligature risks in the environment
- While ligature risks are being removed, policies and procedures must be in place to mitigate the harm posed by such risks

Mitigation Plans for Ligature Risks

- Leadership and staff are aware of the risks
- Patients are identified and interventions implemented based on risk
- At-risk behavior is assessed and reassessed
- Staff are trained to identify risks and implement interventions
- Suicide risk and self-harm reduction strategies are included in the overall Quality Assessment and Performance Improvement Program
Non-Behavioral Health Care Units

- Emergency Rooms and Medical Inpatient Units that are NOT DESIGNATED specifically for the treatment of psychiatric patients
- Risks must be identified and those that can be removed are removed and those that cannot be moved are mitigated through effective surveillance

Medical Staff Chapter

I. Medical Staff Bylaws (MS.01.01.01, MS.01.01.05, MS.01.01.09)
II. Structure and Role of Medical Staff Executive Committee (MS.02.01.01)
III. Medical Staff Role in Oversight of Care, Treatment, and Services (MS.03.01.01, MS.03.01.09)
IV. Medical Staff Role in Graduate Education Programs (MS.04.01.01)
V. Medical Staff Role in Performance Improvement (MS.05.01.01, MS.05.01.09)
VI. Credentialing and Privileging (MS.06.01.01, MS.06.01.03, MS.06.01.09, MS.06.01.11, MS.06.01.13, MS.06.01.15)
VII. Appointment to Medical Staff (MS.07.01.01, MS.07.01.02)
VIII. Evaluation of Practitioners (MS.08.01.01, MS.08.01.02)
IX. Fair Hearing and Appeal Process (MS.10.01.01)
X. Licensed Independent Practitioner Health (MS.11.01.01)
XI. Continuing Education for Practitioners (MS.12.01.01)
XII. Medical Staff Role in Telemedicine (MS.13.01.01, MS.13.01.02)

Medical Staff Chapter

- 2015—Six percent of standards and elements of performance scored as insufficient compliance
- 24 Elements of Performance accounted for 77%
- 100 EPs scored in less than 1% of surveys
- 38 EPs never scored in 2015
Medical Staff Standards Summary--2015

<table>
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<tr>
<th>Medical Staff Standards</th>
<th>Standard rate of non-compliance</th>
<th>EPs with highest rate of non-compliance</th>
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<td>MS.01.01.01</td>
<td>32.5%</td>
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<td>MS.08.01.03</td>
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<tr>
<td>MS.06.01.07</td>
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2015 Commonly Scored Medical Staff Standards

- MS.01.01.01, Bylaws, EPs 3 and 5
- MS.08.01.03, OPPE, EPs 1 and 3
- MS.08.01.01, FPPE, EPs 1 and 3
- MS.03.01.01, Oversight, EPs 2 and 7
- MS.06.01.03, Credentialing, EPs 5 and 6
- MS.06.01.05, Privileging, EPs 2 and 7
- MS.06.01.07, Reviews, EP 9

Medical Staff Bylaws

- MS.01.01.01, 37 Elements of Performance
- Address self governance and accountability to the governing body
- Bylaws must contain all Elements of Performance 12 – 37
- EP 3 is scored plus any missing EP in 12 - 37
Compliance with MS.01.01.01

- Complete an analysis of Bylaws for presence of EPs 12 – 37
- Each EP must be addressed although details may be contained in a Policy Manual
- EP 12 requires the Bylaws describe the Structure of the Medical Staff

MS.01.01.01, Membership EPs

- Membership on the Medical Staff is defined by
  - Qualifications to be a member (13)
  - A process to delineate privileges and renew privileges (14)
  - Members assigned to a category with defined duties and rights (15) including voting rights (17)
  - A process to credential and recredential (26)
  - A process to appoint and reappoint (27)

MS.01.01.01, Removal EPs

- Members of the medical staff may be removed by automatic suspension, summary suspension, or termination/reduction of privileges
  - Indications are described for automatic (28), summary (29), and termination/reduction (30)
  - Process is described for automatic (31), summary (32), and termination/reduction (33)
MS.01.01.01, Fair Hearing EPs

- Members have a right to appeal decisions through a fair hearing
- The process to schedule and conduct a fair hearing is described
- The composition of the fair hearing committee is described
- Full descriptions may be contained in a Fair Hearing and Appeal Manual

MS.01.01.01, Officers

- Officers of the Medical Staff
- Are listed in the Bylaws
- A process is described to elect and remove medical staff officers
- When Departments exist the bylaws contain the qualifications of the Chairs and their roles and responsibilities

MS.01.01.01, MEC

- Medical Executive Committee
- Function and size is described
- Selection and removal of members
- Composition including non-medical staff members
- MEC authority is described and when MEC acts for the Medical Staff
- Conflict resolution between MEC and Medical Staff
**MS.01.01.01**

- Process to adopt and amend Bylaws, Policies and Rules and Regulations
  - Bylaws (24)
  - Policies, Rules and Regulations (25)
- Basic requirements for History and Physical Examination, practitioners that may perform, and update (16)
- Unified and integrated medical staff of a multihospital system can opt out for their specific hospital with majority vote (37)

**MS.01.01.01, EP 5**

- The medical staff complies with the medical staff bylaws, rules and regulations and policies
- Examples
  - Any documentation that does not have all required elements required by medical staff—H&P, Op Note, Discharge Summary, Orders for Imaging includes an indication
  - Documentation not entered within time frames required by the medical staff
  - Countersignature or attestations of documentation performed by advanced practice providers/residents within required time frame

**Ongoing Professional Practice Evaluation**

- MS.08.01.03
  - EP 1—Clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice
  - EP 3—Information from OPPE is used to determine whether to continue, limit or revoke and existing privilege
Examples of OPPE Findings

- Ongoing is defined as less than 12 months
- The process must consider practice variations of practitioners
  - Core measures do not apply to all medical staff members, do measures reflect privileges?
  - Attribution issues related to advanced practice providers, they require a different process and this process must be described
  - Must include more than peer review
    - Relationship between OPPE and privileges
    - What is your return on investment to protect patients with your OPPE process?

OPPE: Performance Improvement

- Selection of Metrics
- Education, Simulation, Training, Coaching
- Physicians Review Performance Reports
- Departmental Review and Analysis
- Accuracy in Measurement

OPPE for Advanced Practice Providers

- Advanced Practice Providers: CRNA, CNM, APRN, PA, AA
- Information systems report based on physician so often no readily available data
- What can we use?
OPPE for Advanced Practice Providers

- What data can be used for OPPE?
  - Periodic chart review
  - Direct observation
  - Monitoring of diagnostic and treatment techniques
  - Discussion with other individuals involved in the care of each patient

Better Practice

- Direct observation and evaluation of a patient encounter by a peer advanced practice provider and/or sponsoring physician which may include discussion with others involved in care
- Evaluation form used to track observations
  - Medical record number used to document the specific patient encounter
  - Questions concern important care, treatment and services answered with a Yes, No or Not Applicable
  - Medical Staff determines how many observations are required
- This process is described in the OPPE Policy

Advanced Practice Provider Evaluation

- Was the H&P complete and pertinent?
- Do progress notes reflect and follow the patient’s treatment?
- Were lab and imaging studies appropriately ordered?
- Were medication orders appropriate (antimicrobials) and was medication reconciliation completed?
- Appropriate and timely consultations?
- Informed consent, time out, sterile technique?
- Overall evaluation for the reporting period?
FPPE/OPPE Evaluation Form

Focused Professional Practice Evaluation

- MS.08.01.01
  - EP 1—A period of FPPE is implemented for all initially requested privileges
    - Effective January 1, 2008
    - No exceptions
    - Example of finding—Not done for one or more medical staff members
Focused Professional Practice Evaluation

- MS.08.01.01
  - EP 3—The performance monitoring process is clearly defined and includes each of the following elements
    - Criteria for conducting performance monitoring
    - Method for establishing a monitoring plan specific to the requested privilege
    - Method for determining the duration of performance monitoring
    - Circumstances under which monitoring by an external source is required
  - Example of finding—any element is missing or no process

- Example of finding
  - Infrequently reported FPPE findings on survey
  - EP 4—Requires consistent implementation of FPPE
    - Example—OPPE indicates concerns and no action taken
  - EP 5—Requires clearly defined triggers to indicate the need for performance monitoring
    - Example—the process does not clearly define triggers which could be a single incident or a trend

Verification

- MS.06.01.03—The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege
  - Examples of findings
    - EP 5—No evidence of verification of identification, valid photo id
      - Only required for initial appointment
    - EP 6—No verification of licensure, training or competence
      - Licensure is verified initially, on renewal or revision of privileges, and at the time of expiration
Privileging

- MS.06.01.05—The decision to grant, or deny, a privilege(s) and/or to renew an existing privilege is an evidence-based process
  - Examples of findings
    - No criteria established to be eligible for privileges
    - Privileges granted or renewed without primary source verification of required elements
      - Note—Primary Source Verification of DEA is not required by The Joint Commission unless the Medical Staff requires it
    - No criteria developed for granting privileges for moderate sedation

Privileging, MS.06.01.05, EP 2

- The hospital, based on recommendations by the organizational medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
  - Current license and/or certification, as appropriate, verified with the primary source
  - The applicant's specific relevant training, verified with the primary source
  - Evidence of physical ability to perform the requested privilege
  - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
  - Peer and/or faculty recommendation

- When renewing privileges, review of the practitioner's performance within the hospital

Privileging

- MS.06.01.05, EP 7
  - The hospital queries the National Practitioner Data Bank when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested
Reappointment

- MS.06.01.07
  - EP 2—Privileges are granted for a period not to exceed two years
  - Examples of findings
    - Practice was to reappoint every three years
    - Appointments had expired prior to the survey and the practitioner(s) were still providing services to the hospital
    - Note—Lack of privileges is scored at MS.03.01.01 EP2